

THE NEXT ANNUAL MEETING.

Do not forget that the next annual meeting of the State Society will be held April 15, 16 and 17; Tuesday, Wednesday and Thursday. The various county societies did not vote to change the time of the meeting. The Chairman of the Committee on Scientific Work is Dr. Dudley Fulton, of Los Angeles and those who desire to present papers should write to him at once, "lest they get left." Begin right now to make your plans to attend this meeting. In the House of Delegates, every county society should have its full representation, as matters of the utmost importance will come before that body. A recommendation will be made that the Medical Defense rules be amended so as to exclude from protection (after a date at least six months in advance) any member who may be sued for alleged malpractice in the treatment of any fracture or any surgical operation, unless he had a consultant at the time of treatment or operation. That is worth careful thought. Also, the increase in the number of such suits and the very great increase in the cost of protecting them, will come up for discussion and action. Make your plans now to attend the meeting in April.

EDUCATIONAL ASSISTANCE.

Unfortunately, we none of us know so much that we cannot be taught a little more; some of us would be benefited by a whole lot of teaching! Apropos of this fact the suggestion has been made to us that it would be a good plan, if practicable, for the American Medical Association to employ a certain number of competent teachers to go about the country visiting the various county societies and staying long enough to give courses of lectures or instruction in the more recent advances of medicine. It is difficult for the busy practitioner, especially in the country, where distances are great, to keep up with what is being discovered in these progressive days. More than likely there are a good many physicians to whom "Wassermann," "luetin," etc., are but vague words. The idea is very "sketchy" and may not be practicable, but we turn it over to the Association authorities to consider and do with as they please.

WIDELY DISTRIBUTED INTEREST.

It has been a matter not only of great interest but of some small pleasure to note the widely distributed territory in which the JOURNAL seems to be of enough interest to be fairly well read—or looked through. A few copies go into nearly every state in the United States and some to England and Europe generally. At least one reader in every state in which the JOURNAL circulates, has written to us asking for "stickers" which were first advertised in the September issue; two or three requests have come from England and Canada and the following post-card was recently received from a reader in Germany: "You would much oblige us by sending us a set of 'stickers' as mentioned in the STATE JOURNAL ADVERTISER." Even our advertising pages seem to be worth the attention of a good many who receive the JOURNAL; they are

readers who are up-to-date; no one can be up-to-date, in these days, unless he pays attention to the advertising pages of the reputable publications that pass through his hands.

ORIGINAL ARTICLES

ON THE TOLERANCE OF THE VITREOUS TO DISLOCATED LENSES, AS AN INDEX TO RECLINATION IN GIVEN CASES.*

By P. de OBARRIO, M. D., San Francisco.

It has been my privilege to come in contact in my years of practice in the tropics with a number of unusually complicated and neglected eye affections. I said privilege to the full extent of the word, for the important reason that, because of the same neglect I have been able to gather most valuable data, which I feel would have been impossible to get in the neighborhood of large centers with hospital facilities and public clinics, as these cases would have been in all probability attended to, and the opportunity of observing the very late results of a good many ocular affections not subjected to treatment would have been lost.

Due to this same reason I have been able to report the largest case of binocular, double internal and external pterygia on record¹ giving in detail the manner of treatment and mentioning some original observations concerning the prognosis of these cases as regards the distribution of capillaries of new formation after surgical intervention, based on an extensive experience on the treatment of this affection.

Such observations have been favorably confirmed and commented upon by my friend and colleague, Professor Terson of the University of Paris, in his most excellent and instructive article describing his recent and new procedure in the surgical technic of pterygia, which to my mind is exceptionally good and to which I expect to dedicate a special chapter.²

On the same order of things I have met and kept in touch with the cases that I am about to report from which I have drawn such conclusions as have at a later period guided me in the successful management of complicated cases in a manner that is neither taught nor learned except by coming in contact with this kind of material which is not generally found in the clinics. These cases have been both traumatic and post-operative and I take them from my practice as they have come to my observation from time to time and in different countries.

The first case is that of Mr. S., thirty years of age, a druggist as well as farm owner, whom I saw for the first time in the Republic of Salvador, the year 1902. He came to my office to be prescribed for glasses and I at once observed that his right eye was aphakic.

He explained to me that seven years previous he had been thrown from his horse and had received a violent blow on this eye. After the reaction subsided he noticed that he could see much less out of this eye.

The ophthalmoscope revealed the presence of an

* Read before the Forty-Second Annual Meeting of the State Society, Del Monte, April, 1912.

opaque lens dislocated downwards into the vitreous chamber very freely movable and attached to the ciliary region only by a slight filament. He claimed he was never troubled by this eye, with the exception of conjunctival irritations in both eyes from time to time, due principally to his out of doors life, exposed to the great tropical heat and dusty roads. The lens was apparently not much reduced in size and his vision was improved to 20/30 with a plus 10 D. I advised him to seek treatment the moment he noticed any reaction on this eye.

I have recently heard from a physician friend, who resides in San Salvador who is personally acquainted with the case and he informs me that the patient is doing well; has never had any particular trouble with this eye and has required no treatment. This case, therefore, has had a dislocated lens in his vitreous during seventeen years and has not been any worse for it. A partial or total absorption of his lens must have taken place and it is fair to assume that if after these many years he has had no reaction, the chances for any further trouble are very slim.

The second case is that of a school boy fifteen years of age whom I saw the year 1903 in Panama. The patient had opaque lenses in both eyes as a consequence of having fallen from a carriage three years previous and struck the back of his head on the stone pavement, having been unconscious for over an hour. Both lenses were completely opaque so that he had only light perception. After dilating the pupils, which is a practice I always undertake in every cataract case, I could detect an almost imperceptible tremor of both lenses upon rapid motion of the eyes; but so slight was this that I could not pronounce myself definitely on this matter. I proposed the extraction which was cheerfully accepted.

Immediately after the counter-puncture of the cornea, I noticed that the amount of what seemed to be the aqueous was exceedingly large. Upon closer observation, however, it proved to be nothing else but the greater part of a completely liquefied vitreous which by the time the incision was finished at least one-half had escaped. With great precaution, an attempt was made to extract the lens which turned backwards into the vitreous chamber like a door on its hinges and any further attempt was out of the question.

The iris was carefully replaced into the anterior chamber and a small amount of sterile saline solution injected with a dropper under the cornea in order to replace to a certain extent the great amount of fluid lost.

The patient had an uninterrupted recovery and a very useful eye to the extent of 20/30 with the correcting lens.

Three months after this operation while he was acting as catcher at a baseball game he was struck on his left eye (not operated) with the ball with such force that he was rendered unconscious for a long time. He tells me he had considerable swelling of the lids and that he kept his eyes bandaged for several days. As soon as he was able to open the lids sufficiently he was astonished to observe that he could see out of this eye.

I saw the case one year after the accident and found his left lens dislocated into the vitreous in the same manner as that of his right eye that had been operated upon, and he had an equally good vision out of this eye as of the other. I have observed this case from time to time up to December, 1910, when I left the Isthmus of Panama, and at no time was this patient troubled with his eyes in spite of his being an unusually active and restless youngster.

When I last saw him I observed that neither of the lenses was as freely movable as at an earlier period after their dislocations and apparently they were undergoing gradual absorption as they were

slightly diminished in size. This patient has stood nine years with the lenses in the vitreous and I presume that as he is now quite a young man and his lenses would probably be absorbed, that there is no cause for apprehension in the future.

In 1903 likewise, I had the opportunity to treat a colored boy of about 16 years of age with double traumatic cataracts. Both eyes showed very fluid vitreous and tremulous iris. In this case I did not pretend to attempt any extraction but, based on my previous observations, I deliberately luxated both his lenses backwards and downwards into the vitreous chamber with an interval of ten days between the operation of one eye and that of the other.

The method consisted in performing a very small corneal incision very close to the scleral margin and located towards the external canthus, just sufficiently large to admit the introduction of a medium size strabismus hook which upon being placed into the anterior chamber, it was guided through the pupil into the posterior chamber so that the very tip rested on the upper border of the lens. With one turn of the handle on its axis the lens was made to descend and rotate backwards.

The first eye was operated with local anesthesia and the second with general narcosis. It is important to be positive that the lens remains dislocated as there might be some filaments to pull it back into the pupillary area; however, these details concern another article on some observations pertaining to a series of similar cases.

The patient has had no trouble of any nature with his eyes up to date and his vision was 20/30 with the correcting glasses.

I will not trouble you with the history of the next two cases; they both belong to the laboring classes and were admitted to St. Thomas Hospital at Panama in 1906; one in January, the other one in March. The first case was forty years old and the other thirty-seven. The first case had received a severe blow on his left eye five years previous, while the other patient presented a recent traumatism. Both these patients had necessarily had violent reactions from their external trauma, but as far as their eyes were concerned they presented round, central, movable, jet black pupils with their lenses dislocated into the vitreous, and very useful sight.

Here is then a series of cases in which the lens has been dislocated into the vitreous chamber for periods varying between six and seventeen years, in relation with patients whose ages have varied between fifteen and forty years. The results of these cases are in entire accord with the general knowledge one has on this question of vitreous tolerance to dislocated lenses which fact has been a matter of record since the dawn of ocular surgery. In fact, it was the basis of the method of treatment by reclinacion.

Speaking on this subject Professor Panas of Paris has the following to say:³

"Generally speaking the luxation in the vitreous provokes a lesser reaction than in the anterior chamber. The most frequent complication is an iridocyclitis that is very rarely combined with glaucomatous symptoms. I generally prefer to abstain from interfering, remembering the great tolerance of the vitreous during the practice of reclinacion of the cataract."

Professor Fuchs of Vienna⁴ expresses his views in this manner:

" . . . On the other hand luxation of the lens into the vitreous is the form best tolerated, specially if the lens as time goes on, becomes smaller through resorption. In fact, in the depres-

sion of cataract one used to count upon this tolerance of the eye towards the lens when depressed into the vitreous."

Other authors are of the same opinion.

In view of this fact I believe it is improper and much to the disadvantage of a certain group of cases, to relegate to oblivion a surgical procedure which in its day had a wide range of usefulness. Undoubtedly if we had reliable statistics of the post-operative results in the practice of reclinatio I feel confident that there must have been many disasters which should be attributed principally to the fact of having adopted a trans-scleral puncture as well as to the most important reason of having performed these operations during the pre-aseptic era when surgeons were practically making unconscious stab cultures in the vitreous, a most excellent medium for bacterial growth.

As an immediate result of these observations, I have established for some time past the practice of reclinatio in the treatment of tremulous cataracts, as the safest means to obviate the dangers of extraction, as there is nothing to support the immediate flow of large quantities of vitreous when the zonula is defective and the vitreous very fluid. The detailed observations relating to a series of such cases is the basis of another study.

I will insist on the fact that if in some of these cases which have been the consequence of violent traumatism and have received but very indifferent treatment, the ultimate and remote effects have been so satisfactory, it is proper, natural and logical to presume that under modern aseptic precautions and with the technic I have casually hinted at in the course of these observations, the results should be and in fact are most encouraging.

References.

- (1) "Un caso excepcional de terignon y algunas consideraciones sobre el tratamiento de esta afeccion." Dr. P. de Obarrio—*Anales de Oftalmologia*, Vol. V. Mexico, 1903.
- (2) "Sur la structure, la pathogenie et une operation modifiee du pterygion." A. Terson, *Archives Ophthalmologie*, Paris, Mars, 1911.
- (3) *Traite des maladies des yeux*, pages 613-614.
- (4) *Text Book of Ophthalmology*, page 392.

Discussion.

Dr. Kaspar Pischel, San Francisco: In former centuries "Staar-Stecher," who were not physicians, traveled from town to town during fair-time to make reclinations. The scientific surgeons gave up reclinatio of cataract in the nineteenth century, principally on account of the frequent occurrence of glaucoma after such operations; the fact that asepsis was not known at that time must have contributed a good deal toward unfavorable results.

Dr. Vard H. Hulén, San Francisco: I believe with Dr. de Obarrio that there are cases that could rightly be submitted to the reclinatio operation. Several years ago I reported at the meeting of the American Medical Association an experience with a cataract patient. Many years before I saw the patient his right eye had been operated upon by a competent man and the cornea was left opaque. I was called upon to operate upon the left eye and thinking that possibly the methods of handling his eye might have something to do with the opacity of the cornea I took every precaution with the second eye. There were no complications but the cornea was left opaque. I reported this case before the Section on Ophthalmology of the American Medical Association and stated that if I had another opportunity to operate upon such a patient

that I would feel justified in doing a reclinatio in the second eye. The discussion was overwhelming against the suggestion and I mention it now because with Dr. de Obarrio's contribution I should feel more encouraged to try it in such a case than I did then.

Dr. P. de Obarrio, San Francisco: The subject of this paper is but a preliminary investigation as to the tolerance the vitreous has to the dislocated lense and a subsequent paper will follow in which I will relate my experiences with several cases. The question of reclinatio has been a matter of practice since the dawn of ocular surgery. The operation of reclinatio is practiced to-day daily in India. It is a pity that it is in the hands of non-professional men that do not observe the proper technic and they have no knowledge of the anatomy of the place upon which they are operating. With all that, their results are very frequently brilliant. The application of reclinatio in tremulous cataracts I believe is a very valuable procedure and I have adopted it regularly for years past.

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NEUROSES OF THE MOUTH AND THROAT.*

By M. W. FREDRICK, M. D., San Francisco.

No doubt a number of you have experienced the elderly lady, generally of Hebraic or Celtic extraction, who positively asserted, and had a mass of historical facts to bear out her assertion, that she had a hair in her throat which had been there for many days. After several vain attempts to find the hair either the patient concludes to try some more skillful practitioner, or she has been rid of her hair by psychotherapy and mild local measures. Nothing is more exasperating than the search for a peg upon which to hang a diagnosis without discovering the slightest excrescence to support an opinion. We feel that we may be amongst those against whom the medical epigram "More mistakes are made by not seeing than by not knowing" is directed, and we tire our eyes and brain trying to discover even the smallest objective change which might justify the patient's subjective symptoms.

Lippincott's definition of neurosis is: a functional nervous disease; an affection of the nervous system occurring without any material change producing it, without inflammation or other structural change which can be detected in the nervous centers. Against this I would like to place the definition of John McCrae in Osler's system, Vol. V, page 86: "There is a tendency to think that neuroses exist without organic lesions, but in the esophagus, as elsewhere, it is well to remember that some lesion may exist which is a point of origin for the stimuli that call forth the symptoms. The lesion may be, often is, quite inconsiderable, and out of proportion to the symptoms it excites, but the effects of treatment will be much better if it be borne in mind that such may exist. In many cases it must be admitted that not the slightest deviation from the normal is to be detected."

It is according to the latter conception that I have written a few words.

* Read before the San Francisco Polyclinic Society, April 3d, 1912.